adenocarcinoma (AC) or squamous cell carcinoma (SCC) by standard histopathologic methods." In fact, adding a new diagnostic tool to the classical diagnostic tool might improve the diagnostic ability. Focusing on the use of microRNAassays, there are still left concern and questions on the cost effectiveness, availability, and complexity of the tests. These points have to be further discussed. Focusing on MiR-205 MicroRNA, its diagnostic value for differentiating between AC and SCC is still controversial. Some previous reports showed limitation of its ability to diagnose SCC.[2] Also, the MiR-205 can also increase in the case with severe inflammation and benign tumor.[3] The possibility of false-positive because of noncancerous lesion has to be further studied.

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Reply to "MiR-205 and miR-375 microRNA Assays to Distinguish Squamous Cell Carcinoma From Adenocarcinoma in Lung Cancer Biopsies"

In Response:

We thank Dr. Wiwanitkit for his comments on our study.[1] The microRNA-based assay described in it requires the quantification of only four RNAs (*miR-21*, *miR-205*, and *miR-375*, and *RNU6B*). As already noted by us in the publication, this can be conveniently done in any laboratory with a quantitative polymerase chain reaction machine, with time and material costs similar to those for immunohistochemistry-based diagnosis of non–small-cell lung cancer histology. However, the suitability of the assay for biospecimens with less than 90% tumor content has not been assessed by us. In our study, microdissection of tumor-containing regions of biopsied material was performed for 76% of biopsies to have ≥90% tumor content in the specimens that were used for RNA extraction for the microRNA-based assay.

The studies on the association of *miR-205* with severe inflammation and benign tumor and the lack of a differential expression of this microRNA between normal and tumor tissues, which Dr. Wiwanitkit refers to, concern oral cancer and not cancer of the lung. In case of the latter, a significantly higher expression of *miR-205* in lung squamous cell carcinoma tissue compared with normal lung, or lung tissue with adenocarcinoma or benign diseases has been noted by many[2–5] and in Figure 1 of our article.[1]

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Reply to "Better Prognostic Models May Result in Improved Patient Selection for Adjuvant Therapies After Complete Resection of Solitary Fibrous Tumors of the Pleura"

In Response:

We would like to thank Dr. Tapias and Dr. Lanuti for their comments on our recent article reporting on a multicenter cohort of 68 patients with solitary fibrous tumors of the pleura (SFTP), who were analyzed for the complete course of the disease in a routine practice setting.[1] We acknowledge that our recurrence rate of 30%

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in nonmetastatic disease was higher than that previously reported in surgical series, including that by Tapias et al.[2] (14%). We hypothesize this may be related to (1) a more limited enrollment period (12 years from 2000 to 2012, versus 33 years from 1977 to 2010 in the Tapias series) together with (2) a prolonged median follow-up of 13 years and (3) the recruitment of cases from medical oncology services, at an advanced stage of the disease then requiring chemotherapy treatment.[1] We agree that incomplete resection may have contributed to this higher recurrence rate, as five patients—four stage II tumors, one stage III tumor—had R1 resection, and two patients—both stage III—had R2 resection. We believe this reflects routine practice, as other surgical series similarly reported incomplete resection to occur in 7% to 11% of malignant SFTP.[3]

On the basis of their series of 59 patients, Tapias et al. propose a scoring system to predict SFTP recurrences; four of the six variables of this scoring are actually common with that of the England/de Perrot staging, including structure, mitotic activity, cellularity, and presence of necrosis.[2] Of note, Tapias et al. did not applied the de Perrot staging to their cases, whereas they stated that scoring was a superior predictor of recurrence.

Comparing our cohort with this series, scores had the following distribution: 0 in 15% versus 42% patients, 1 in 13% versus 19%, 2 in 28% versus 19%, 3 in 19% versus 12%, 4 in 7% versus 5%, 5 in 9% versus 3%, and 6 points in 9% versus 0%. Scoring, although correlating with the de Perrot stage ($p < 0.001$), was also a significant predictor of recurrence-free survival ($p = 0.007$): 3-year, 5-year, 10-year, and 15-year recurrence-free survival rates were 40%, 31%, 25%, and 25%, respectively, for a score ≥3, and 88%, 70%, 58%, and 58%, respectively, for a score <3. These figures are far lower than that reported in the original series by Tapias et al.—80%, 69%, 23%, and 23% for a score ≥3 and 100% for a score of <3—and in a more recent validation cohort.[5] This reflects the higher aggressiveness of our cases that would be even more appreciated using the proposed 6-class score, which may be even more relevant for advanced malignant cases. Whether these analyses are relevant to drive perioperative management still remains to be determined, especially because the efficacy of adjuvant treatment is limited, as highlighted in our cohort.

Ultimately, such major differences between reported series of TFSPs emphasize the need for multicenter collaboration to develop prospective observational cohorts of consecutive patients, what remains challenging given the wide range of aggressiveness of the disease, the long-term survival of patients, and the multidisciplinary management from initial presentation to recurrent disease.

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